

**CMDP**  
**DENTAL BENEFITS MATRIX**  
Effective DOS 10/01/07

BR - By report pays 65% of billed charges				C - Covered Service	
BR *- Orthodontics pays 80% of billed charges				N - Non Covered Service	
Send x-rays for PA requests and retro reviews only				C -PA - Covered with Prior Authorization Only	
DENTAL CODES	DESCRIPTION	COVERAGE CATEGORY	PA PROCEDURES ONLY	AMOUNT	Age
<b>CLINICAL ORAL EVALUATIONS</b>					
D0120	PERIODIC ORAL EVALUATION - Established patient	C		29.50	0-999
D0140	LIMITED ORAL EVALUATION, problem focused	C		39.00	0-999
D0145	Oral evaluation for a patient under three years of age and counseling W/caregiver	C		36.90	0-2
D0150	COMPREHENSIVE ORAL EVALUATION - new or established patient	C		43.30	0-999
D0160	DETAILED & EXTENSIVE ORAL EVALUATION, problem focused	C	INCLUDE NARRATIVE	43.30	0-999
D0170	RE-EVAL LIMITED, problem focused	N			0-999
D0180	COMPREHENSIVE PERIODONTAL EVALUATION- new or established pat.	C		45.40	0-999
<b>RADIOGRAPHS/DIAGNOSTIC IMAGING</b>					
D0210	INTRAORAL - COMP (including bitewings)	C		77.00	0-999
D0220	INTRAORAL - PERIAPICAL FIRST FILM	C		15.80	0-999
D0230	INTRAORAL - PERIAPICAL EACH ADDITIONAL FILM	C		12.70	0-999
D0240	INTRAORAL - OCCLUSAL FILM	C		15.80	0-999
D0250	EXTRAORAL - FIRST FILM	C		17.90	0-999
D0260	EXTRAORAL - EACH ADDITIONAL FILM	C		13.70	0-999
D0270	BITEWING - SINGLE FILM	C		12.70	0-999
D0272	BITEWINGS - TWO FILMS	C		25.30	0-999
D0273	BITEWINGS - THREE FILMS	C		31.70	0-999
D0274	BITEWINGS - FOUR FILMS	C		36.90	0-999
D0277	VERTICAL BITEWINGS - 7 TO 8 FILMS	C		36.90	0-999

**CMDP**  
**DENTAL BENEFITS MATRIX**  
Effective DOS 10/01/07

BR - By report pays 65% of billed charges				C - Covered Service	
BR *- Orthodontics pays 80% of billed charges				N - Non Covered Service	
Send x-rays for PA requests and retro reviews only				C -PA - Covered with Prior Authorization Only	
DENTAL CODES	DESCRIPTION	COVERAGE CATEGORY	PA PROCEDURES ONLY	AMOUNT	Age
D0290	POSTERIOR-ANTERIOR OR LATERAL SKULL/FACIAL BONE SURVEY FILM	C		39.00	0-999
D0310	SIALOGRAPHY	C - PA		BR	0-999
D0320	TEMPOROMANDIBULAR JOINT ARTHROGRAM, INCLUDING INJECTION	C - PA		121.30	0-999
D0321	OTHER TEMPOROMANDIBULAR JOINT FILMS	C		58.00	0-999
D0322	TOMOGRAPHIC SURVEY	N			0-999
D0330	PANORAMIC FILM	C		65.40	0-999
D0340	CEPHALOMETRIC FILM	C		55.90	0-21
D0350	ORAL/FACIAL IMAGES (includes intra and extraoral images)	C		22.20	0-21
D0360	CONE BEAM CT- craniofacial data capture	N			0-999
D0362	CONE BEAM - two-dimensional image reconstruction using existing data	N			0-999
D0363	CONE BEAM -three-dimensional images reconstruction using existing data	N			0-999
<b>TEST AND LABORATORY EXAMINATIONS</b>					
D0415	COLLECTION OF MICROORGANISMS FOR CULTURE AND SINITIVITY	N			0-999
D0416	VIRAL CULTURE	N			0-999
D0421	GENETIC TEST FOR SUSCEPTIBILITY TO ORAL DISEASES	N			0-999
D0425	CARIES SUSCEPTIBILITY TESTS	N			0-999
D0431	ADJUNCTIVE PRE-DIAG NOSTIC TEST THAT AIDS IN DETECTION	N			0-999
D0460	PULP VITALITY TESTS	N			0-999
D0470	DIAGNOSTIC CAST	C - PA	Include Narrative	54.90	0-21
D0472	ACCESSION OF TISSUE, GROSS EXAM, PREP/TRANSMISSION OF WRITTEN REPORT	N			0-999

**CMDP**  
**DENTAL BENEFITS MATRIX**  
Effective DOS 10/01/07

BR - By report pays 65% of billed charges				C - Covered Service	
BR *- Orthodontics pays 80% of billed charges				N - Non Covered Service	
Send x-rays for PA requests and retro reviews only			C -PA - Covered with Prior Authorization Only		
DENTAL CODES	DESCRIPTION	COVERAGE CATEGORY	PA PROCEDURES ONLY	AMOUNT	Age
D0473	ACCESSION OF TISSUE, GROSS/MICRO EXAM, PREP/TRANS OF WRITTEN REPORT	N			0-999
D0474	ACCESS OF TISSUE, GRO/MICRO EXAM, INCL SURG MARGINS, PREP/TRANSM OF RP	N			0-999
D0475	DECALCIFICATION PROCEDURE	N			0-999
D0476	SPECIAL STAINS FOR MICROORGANISIMS	N			0-999
D0477	SPECIAL STAINS NOT FOR MICROORGANISIMS	N			0-999
D0478	IMMUNOHISTOCHEMICAL STAINS	N			0-999
D0479	TISSUE IN-SITU HYBRIDIZATION, INCLUDING INTERPRETATION	N			0-999
D0480	ACCESSION OF EXFOLIATIVE CYTOLOGIC SMEARS, MICRO EXAM. PREP/TRANS OF WRITTEN REPORT	N			0-999
D0481	ELECTRON MICOSCOPY - DIAGNOSTIC	N			0-999
D0482	DIRECT IMMUNOFLUORESCENCE	N			0-999
D0483	INDIRECT IMMUNOFLUORESCENCE	N			0-999
D0484	CONSULTATION ON SLIDES PREPARED ELSEWHERE	N			0-999
D0485	CONSULTATION, INCLUDING PREP OF SLIDES FROM BIOPSY	N			0-999
D0486	ACCESSION OF BRUSH BIOPSY SAMPLE, MICRO EXAM, PREP AND TRAN OF WRITTEN REPORT	N			0-999
D0502	OTHER ORAL PATHOLOGY PROCEDURE	C - PA	Include Narrative	26.40	0-999
D0999	UNSPECIFIED DIAGNOSTIC PROCEDURE	C - PA	Include Narrative	BR	0-999
PREVENTIVE					
D1110	PROPHYLAXIS ADULT	C		52.80	14-999
D1120	PROPHYLAXIS CHILD	C		45.40	0-13
TOPICAL FLUORIDE TREATMENT					

**CMDP**  
**DENTAL BENEFITS MATRIX**  
Effective DOS 10/01/07

BR - By report pays 65% of billed charges				C - Covered Service	
BR *- Orthodontics pays 80% of billed charges				N - Non Covered Service	
Send x-rays for PA requests and retro reviews only				C-PA - Covered with Prior Authorization Only	
DENTAL CODES	DESCRIPTION	COVERAGE CATEGORY	PA PROCEDURES ONLY	AMOUNT	Age
D1203	TOPICAL APPLICATION OF FLUORIDE (prophylaxis not included)-CHILD	C		21.00	0-13
D1204	TOPICAL APPLICATION OF FLUORIDE (prophylaxis not included)-ADULT	C		21.00	14-20
D1206	TOPICAL FLUORIDE VARNISH; THERAPEUTIC APPLICATION FOR MODERATE TO HIGH CARIES RISK	C		21.00	0-20
D1310	NUTRITIONAL COUNSELING FOR CONTROL OF DENTAL DESEASE	N			0-20
D1320	TOBACCO COUNSELING FOR CONTROL OF DENTAL DISEASE	N			0-20
D1330	ORAL HYGIENE INSTRUCTIONS	N			0-20
D1351	SEALANT-PER TOOTH	C	1st & 2nd permanent molars & 2nd primary molars only	28.50	0-20
D1510	SPACE MAINTAINER-fixed-unilateral	C	Premature loss of posterior teeth only	157.20	0-14
D1515	SPACE MAINTAINER-fixed-bilateral	C	Premature loss of posterior teeth only	224.70	0-14
D1520	SPACE MAINTAINER-removable-unilateral	C	Premature loss of posterior teeth only	157.20	0-14
D1525	SPACE MAINTAINER-removable-bilateral	C	Premature loss of posterior teeth only	224.70	0-14
D1550	RECEMENTATION OF SPACE MAINTAINER	C		35.90	0-14
D1555	REMOVAL OF FIXED SPACE MAINTAINER	C		35.90	0-21
RESTORATIVE					
D2140	AMALG -1 SURFACE - primary or permanent	C		77.00	0-999
D2150	AMALG-2 SURFACES - primary or permanent	C		92.80	0-999
D2160	AMALG-3 SURFACES - primary or permanent	C		111.80	0-999
D2161	AMALG 4 + SURFACES - primary or permanent	C		134.00	0-999
D2330	RESIN-BASED COMPOSITE - 1 SURFACE anterior	C		91.80	0-999
D2331	RESIN-BASED COMPOSITE - 2 SURFACES anterior	C		116.10	0-999

**CMDP**  
**DENTAL BENEFITS MATRIX**  
Effective DOS 10/01/07

BR - By report pays 65% of billed charges				C - Covered Service	
BR *- Orthodontics pays 80% of billed charges				N - Non Covered Service	
Send x-rays for PA requests and retro reviews only				C -PA - Covered with Prior Authorization Only	
DENTAL CODES	DESCRIPTION	COVERAGE CATEGORY	PA PROCEDURES ONLY	AMOUNT	Age
D2332	RESIN-BASED COMPOSITE - 3 SURFACES anterior	C		145.60	0-999
D2335	RESIN-BASED COMP 4/+ SURFACES INVOLVING INCISAL ANGLE anterior	C		175.10	0-999
D2390	RESIN-BASED COMPOSITE CROWN anterior	C		211.00	0-999
D2391	RESIN-BASED COMPOSITE - 1 SURFACE posterior	C		77.00	0-999
D2392	RESIN-BASED COMPOSITE - 2 SURFACES posterior	C		92.80	0-999
D2393	RESIN-BASED COMPOSITE - 3 SURFACES posterior	C		111.80	0-999
D2394	RESIN-BASED COMPOSITE 4 + SURFACES posterior	C		134.00	0-999
GOLD RESTORATIONS (02410-02430) not covered					
INLAY/ONLAY RESTORATIONS (02510-02664) not covered					
CROWNS - SINGLE RESTORATIONS ONLY					
D2710	CROWN - RESIN - BASE COMPOSITE (indirect)	N			18-20
D2712	CROWN - 3/4 RESIN BASED COMPOSITE (indirect)	N			18-20
D2720	CROWN - RESIN HIGH NOBLE METAL	N			18-20
D2721	CROWN - RESIN WITH PREDOMINANTLY BASE METAL	N			18-20
D2722	CROWN - RESIN NOBLE METAL	N			18-20
D2740	CROWN - PORC/CERAMIC SUBSTRATE	N			18-20
D2750	CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL root canal teeth except 3rd molars 18-20 years old	C-PA	Include X-ray	600.30	18-20
D2751	CROWN - PORCELAIN FUSED PREDOMINANTLY BASE METAL root canal teeth except 3rd molars 18-20 years old	C - PA	Include X-ray	600.30	18-20
D2752	CROWN - PORC FUSED TO NOBLE METAL root canal teeth except 3rd molars 18-20 years old	C - PA	Include X-ray	600.30	18-20

**CMDP**  
**DENTAL BENEFITS MATRIX**  
Effective DOS 10/01/07

BR - By report pays 65% of billed charges				C - Covered Service	
BR *- Orthodontics pays 80% of billed charges				N - Non Covered Service	
Send x-rays for PA requests and retro reviews only			C -PA - Covered with Prior Authorization Only		
DENTAL CODES	DESCRIPTION	COVERAGE CATEGORY	PA PROCEDURES ONLY	AMOUNT	Age
D2780	CROWN - 3/4 CAST HIGH NOBLE METAL	N			15-20
D2781	CROWN - 3/4 CAST PREDOMINATELY BASED METAL	N			18-20
D2782	CROWN - 3/4 CAST NOBLE METAL	N			0-999
D2783	CROWN - 3/4 PORCELAIN/CERAMIC	N			0-999
D2790	CROWN - FULL CAST HIGH NOBLE METAL root canal teeth except 3rd molars 18-20 years old	C-PA	Include X-ray	600.30	18-20
D2791	CROWN FULL CAST PREDOM BASE MET root canal teeth expect 3rd molars 18-20 years old	C - PA	Include X-ray	600.30	18-20
D2792	CROWN FULL CAST NOBLE METAL root canal teeth except 3rd molars 18-20 years old	C - PA	Include X-ray	600.30	18-20
D2794	CROWN-TITANIUM root canal teeth except 3rd molars	C-PA	Include X-ray	400.00	0-999
D2799	PROVISIONAL CROWN	N			0-999
OTHER RESTORATIVE SERVICES					
D2910	RECEMENT INLAY, ONLAY, OR PARTIAL COVERAGE RESTORATION	C		48.50	18-999
D2915	RECEMENT CAST OR PREFABRICATED POST AND CORE	C		48.50	0-999
D2920	RECEMENT CROWN	C		48.50	0-999
D2930	PREFABRICATED STAINLESS STEEL CROWN (primary tooth)	C		142.40	0-14
D2931	PREFABRICATED STAINLESS STEEL CROWN (permanent tooth)	C		165.60	6-999
D2932	PREFABRICATED RESIN CROWN	C		140.30	6-999
D2933	PREFABRICATED STAINLESS STEEL CROWN W/RESIN WINDOW	C		166.70	0-999
D2934	PREFABRICATED ESTHETHIC COATED STAINLESS STEEL CROWN	C	(primary tooth)	166.70	0-20
D2940	SEDATIVE FILLING	C		53.80	0-999
D2950	CROWN BUILDUP (including any pins)	C		147.70	0-999
D2951	PIN RETENTION - PER TOOTH (in addition to restoration)	C		42.20	0-999

**CMDP**  
**DENTAL BENEFITS MATRIX**  
Effective DOS 10/01/07

BR - By report pays 65% of billed charges				C - Covered Service	
BR *- Orthodontics pays 80% of billed charges				N - Non Covered Service	
Send x-rays for PA requests and retro reviews only				C -PA - Covered with Prior Authorization Only	
DENTAL CODES	DESCRIPTION	COVERAGE CATEGORY	PA PROCEDURES ONLY	AMOUNT	Age
D2952	CAST POST AND CORE (in addition to crown) indirectly facricated	C		223.70	0-999
D2953	EACH ADDITIONAL CAST POST (same tooth)	N			0-999
D2954	PREFABRICATED POST AND CORE (in addition to crown)	C		134.00	0-999
D2955	POST REMOVAL (not in conjunction with endodontic therapy)	N			0-999
D2957	EACH ADDITIONAL PREFABRICATED POST (same tooth)	N			0-999
D2960	LABIAL VENEER (resin laminate) - chairside	N			0-999
D2961	LABIAL VENEER (resin laminated) laboratory	N			0-999
D2962	LABIAL VENEER (porcelain laminate) laboratory	N			0-999
D2970	TEMPORARY CROWN (fractured tooth)	N			0-999
D2971	ADDITIONAL PROCEDURES TO CONSTRUCT NEW CROWN	N			0-20
D2975	COPING	N			0-20
D2980	CROWN REPAIR	N			0-999
D2999	UNSPECIFIED RESTORATIVE PROCEDURE	C - PA	Narrative	BR	0-999
ENDODONTICS					
D3110	PULP CAP - DIRECT (excluding final restoration)	C		20.00	0-20
D3120	PULP CAP - INDIRECT (excluding final restoration)	C		20.00	0-20
D3220	THERAPEUTIC PULPOTOMY (excluding final restoration)	C		85.50	0-999
D3221	PULPAL DEBRIDEMENT (primary and permanent teeth)	C		85.50	0-999
D3230	PULPAL THERAPY (resorbable filling) anterior, primary tooth (excl final resto)	C		110.00	0-12
D3240	PULPAL THERAPY (resorbable filling) posterior, primary tooth (excl final resto)	C		110.00	0-14

**CMDP**  
**DENTAL BENEFITS MATRIX**  
Effective DOS 10/01/07

BR - By report pays 65% of billed charges				C - Covered Service	
BR *- Orthodontics pays 80% of billed charges				N - Non Covered Service	
Send x-rays for PA requests and retro reviews only			C -PA - Covered with Prior Authorization Only		
DENTAL CODES	DESCRIPTION	COVERAGE CATEGORY	PA PROCEDURES ONLY	AMOUNT	Age
ROOT CANAL THERAPY (including follow-up care)					
D3310	ANTERIOR (excluding final restoration) 6,7,8,9,10,11,22,23,24,25,26,27	C		390.40	0-999
D3320	BICUSPID (excluding final restoration) 4,5,12,13,20,21,28,29	C		471.60	0-999
D3330	MOLAR (excluding final restoration) 2,3,14,15,18,19,30,31	C		591.90	0-999
D3331	TREATMENT OF ROOT CANAL OBSTRUCTION (non surgical access)	C		109.70	0-999
D3332	INCOMPLETE ENDODONTIC THERAPY (inoperable,unrestorablr or fractured tooth)	C		224.70	0-999
D3333	INTERNAL ROOT REPAIR OF PERFORATION DEFECTS	C		124.50	0-999
D3346	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY (anterior)	C		501.10	0-999
D3347	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY (bicuspid)	C		527.50	0-999
D3348	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY (molar)	C		627.70	0-999
D3351	APEXIFICATION/RECALCIFICATION (initial visit)	C		93.90	0-999
D3352	APEXIFICATION/RECALCIFICATION (interim medication replacement)	C		79.10	0-999
D3353	APEXIFICATION/RECALCIFICATION (final visit)	C		253.20	0-999
D3410	APICOECTOMY/PERIRADICULAR SURGERY (anterior)	C		358.70	0-999
D3421	APICOECTOMY/PERIRADICULAR SURGERY (bicuspid - 1st root)	C		358.70	0-999
D3425	APICOECTOMY/PERIRADICULAR SURGERY (molar - 1st root)	C		415.70	0-999
D3426	APICOECTOMY/PERIRADICULAR SURGERY (each additional root)	C		179.40	0-999
D3430	RETROGRADE FILLING (per root)	C		125.50	0-999
D3450	ROOT AMPUTATION (per root)	C		206.80	0-999
D3460	ENDODONTIC ENDOSSEOUS IMPLANT	N			0-999



**CMDP**  
**DENTAL BENEFITS MATRIX**  
Effective DOS 10/01/07

BR - By report pays 65% of billed charges				C - Covered Service	
BR *- Orthodontics pays 80% of billed charges				N - Non Covered Service	
Send x-rays for PA requests and retro reviews only				C -PA - Covered with Prior Authorization Only	
DENTAL CODES	DESCRIPTION	COVERAGE CATEGORY	PA PROCEDURES ONLY	AMOUNT	Age
D3470	INTENTIONAL REIMPLANTATION (including necessary splinting)	C		450.50	0-999
D3910	SURGICAL PROCEDURE FOR ISOLATION OF TOOTH (w/rubber dam)	N			0-999
D3920	HEMISECTION (including any root removal) not including root canal therapy	C		206.80	0-999
D3950	CANAL PREPARATION & FITTING OF PREFORMED DOWEL OR POST	N			0-999
D3999	UNSPECIFIED ENDODONTIC PROCEDURE	C		BR	0-999
PERIODONTICS (when medically necessary)					
D4210	GINGIVECTOMY OR GINGIVOPLASTY 4+ contiguous or bounded teeth (per quadrant)	C		287.00	0-999
D4211	GINGIVECTOMY OR GINGIVOPLASTY 1 - 3 contiguous or bounded teeth (per quadrant)	C		111.80	0-999
D4230	ANATOMICAL CROWN EXPOSURE four or more contiguous teeth per Quadrant	N			0-21
D4231	ANATOMICAL CROWN EXPOSURE one to three teeth per Quadrant	N			0-999
D4240	GINGIVAL FLAP, INCLUDING ROOT PLANING 4+contiguous or bounded teeth (per quadrant)	C - PA	Include Narrative, Perio chart, X-Rays	327.10	0-999
D4241	GINGIVAL FLAP, INCLUDING ROOT PLANING 1 - 3 contiguous or bounded teeth (per quadrant)	C - PA	Include Narrative, Perio chart, X-Rays	196.20	0-999
D4245	APICALLY POSITIONED FLAP	N			0-999
D4249	CLINICAL CROWN LENGTHENING (hard tissue)	C		422.00	0-999
D4260	OSSEOUS SURGERY PER QUAD	C - PA	Include Narrative, Perio chart	523.30	0-999
D4261	OSSEOUS SURGERY PER QUAD	C - PA	Include Narrative, Perio chart	341.80	0-999
D4263	BONE REPLACEMENT GRAFT -first site in quadrant	C - PA	Include Narrative, Perio chart, X-Rays	290.10	0-999
D4264	BONE REPLACEMENT GRAFT -each additional site in quadrant	C - PA	Include Narrative, Perio chart, X-Rays	274.30	0-999
D4265	BIOLOGIC MATERIALS TO AID IN SOFT AND OSSEOUS TISSUE REGENERATION	C - PA	Include Narrative, Perio chart, X-Rays	311.20	0-999
D4266	GUIDED TISSUE REGENERATION - resorbable barrier, per site	C - PA	Include Narrative, Perio chart, X-Rays	298.60	0-999

**CMDP**  
**DENTAL BENEFITS MATRIX**  
Effective DOS 10/01/07

BR - By report pays 65% of billed charges				C - Covered Service	
BR *- Orthodontics pays 80% of billed charges				N - Non Covered Service	
Send x-rays for PA requests and retro reviews only			C -PA - Covered with Prior Authorization Only		
DENTAL CODES	DESCRIPTION	COVERAGE CATEGORY	PA PROCEDURES ONLY	AMOUNT	Age
D4267	GUIDED TISSUE REGENERATION - nonresorbable barrier, per site	C - PA	Include Narrative, Perio chart, X-Rays	321.80	0-999
D4268	SURGICAL REVISION PROCEDURE, per tooth	N			0-999
D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	C		320.70	0-999
D4271	FREE SOFT TISSUE GRAFT PROCEDURE	C		381.90	0-999
D4273	SUBEPITHELIAL CONNECTIVE TISSUE GRAFT PROCEDURES, per tooth	C		543.30	0-999
D4274	DISTAL OR PROXIMAL WEDGE PROCEDURE	C		336.50	0-999
D4275	SOFT TISSUE ALLOGRAFT	C		423.10	0-999
D4276	COMBINED CONNECTIVE TISSUE & DOUBLE PEDICLE GRAFT	C		548.60	0-999
D4320	PROVISIONAL SPLINTING (intracoronaral)	C		185.70	0-999
D4321	PROVISIONAL SPLINTING (extracoronaral)	C		142.40	0-999
D4341	PERIO SCALING & ROOT PLANING 4 + teeth (per quadrant)	C - PA	Include Narrative, Perio Chart, X-Rays	153.00	0-999
D4342	PERIO SCALING & ROOT PLANING 1 - 3 teeth (per quadrant)	C - PA	Include Narrative, Perio Chart, X-Rays	90.70	0-999
D4355	FULL MOUTH DEBRIDEMENT TO ENABLE COMPREHENSIVE EVAL. & DIAG.	C		79.10	0-999
D4381	LOCAL DELIVERY CHEMOTHERAPEUTIC AGENTS (per tooth)	N			0-999
D4910	PERIODONTAL MAINTENANCE	C		76.00	0-999
D4920	UNSCHEDULED DRESSING CHANGE (by someone other than treating dentist)	C		31.70	0-999
D4999	UNSPECIFIED PERIODONTAL PROCEDURE	C - PA	Include Narrative	BR	0-999
PROSTHODONTICS - removable - (incl/routine post -delivery care) (when medically necessary)					
D5110	COMPLETE DENTURE (maxillary)	C - PA	Include Narrative	778.60	0-999
D5120	COMPLETE DENTURE (mandibular)	C - PA	Include Narrative	778.60	0-999

**CMDP**  
**DENTAL BENEFITS MATRIX**  
Effective DOS 10/01/07

BR - By report pays 65% of billed charges				C - Covered Service	
BR *- Orthodontics pays 80% of billed charges				N - Non Covered Service	
Send x-rays for PA requests and retro reviews only				C -PA - Covered with Prior Authorization Only	
DENTAL CODES	DESCRIPTION	COVERAGE CATEGORY	PA PROCEDURES ONLY	AMOUNT	Age
D5130	IMMEDIATE DENTURE (maxillary)	C - PA	Include Narrative	873.50	0-999
D5140	IMMEDIATE DENTURE (mandibular)	C - PA	Include Narrative	873.50	0-999
D5211	MAXILLARY PARTIAL DENTURE - resin base (inc/conventional clasps, rests & teeth)	C - PA	Include Narrative	728.00	0-999
D5212	MANDIBULAR PARTIAL DENTURE - resin base (incl/convent'l clasps, rests & teeth)	C - PA	Include Narrative	728.00	0-999
D5213	MAXILLARY PARTIAL DENTURE (cast metal framework with resin bases)	C - PA	Include Narrative	854.60	0-999
D5214	MANDIBULAR PARTIAL DENTURE (cast metal framework with resin bases)	C - PA	Include Narrative	854.60	0-999
D5225	MAXILLARY PARTIAL DENTURE flexible base	N			0-20
D5226	MANDIBULAR PARTIAL DENTURE flexible base	N			0-20
D5281	REMOVABLE UNILAT PARTIAL DENTURE (one piece cast metal - incl clasps/teeth)	C		379.80	0-999
D5410	ADJUSTMENT COMPLETE DENTURE (maxillary)	C		42.20	0-999
D5411	ADJUSTMENT COMPLETE DENTURE (mandibular)	C		42.20	0-999
D5421	ADJUSTMENT PARTIAL DENTURE (maxillary)	C		42.20	0-999
D5422	ADJUSTMENT PARTIAL DENTURE (mandibular)	C		42.20	0-999
D5510	REPAIR BROKEN COMPLETE DENTURE BASE	C		111.80	0-999
D5520	REPLACE MISSING OR BROKEN TEETH (complete denture, each tooth)	C		85.50	0-999
D5610	REPAIR RESIN DENTURE BASE	C		78.10	0-999
D5620	REPAIR CAST FRAMEWORK	C		89.70	0-999
D5630	REPAIR OR REPLACE BROKEN CLASP	C		91.80	0-999
D5640	REPLACE BROKEN TEETH (per tooth)	C		85.50	0-999
D5650	ADD TOOTH TO EXISTING PARTIAL DENTURE	C		101.30	0-999

**CMDP**  
**DENTAL BENEFITS MATRIX**  
Effective DOS 10/01/07

BR - By report pays 65% of billed charges				C - Covered Service	
BR *- Orthodontics pays 80% of billed charges				N - Non Covered Service	
Send x-rays for PA requests and retro reviews only				C -PA - Covered with Prior Authorization Only	
DENTAL CODES	DESCRIPTION	COVERAGE CATEGORY	PA PROCEDURES ONLY	AMOUNT	Age
D5660	ADD CLASP TO EXISTING PARTIAL DENTURE	C		135.00	0-999
D5670	REPLACE ALL TEETH & ACRYLIC FRAMEWORK (maxillary)	N			0-999
D5671	REPLACE ALL TEETH & ACRYLIC FRAMEWORK (mandibular)	N			0-999
D5710	REBASE COMPLETE MAXILLARY DENTURE	C		324.90	0-999
D5711	REBASE COMPLETE MANDIBULAR DENTURE	C		324.90	0-999
D5720	REBASE MAXILLARY PARTIAL DENTURE	C		324.90	0-999
D5721	REBASE MANDIBULAR PARTIAL DENTURE	C		324.90	0-999
D5730	RELINE COMPLETE MAXILLARY DENTURE (chairside)	C		179.40	0-999
D5731	RELINE COMPLETE MANDIBULAR DENTURE (chairside)	C		179.40	0-999
D5740	RELINE MAXILLARY PARTIAL DENTURE (chairside)	C		164.60	0-999
D5741	RELINE MANDIBULAR PARTIAL DENTURE (chairside)	C		164.60	0-999
D5750	RELINE COMPLETE MAXILLARY DENTURE (laboratory)	C		251.10	0-999
D5751	RELINE COMPLETE MANDIBULAR DENTURE (laboratory)	C		251.10	0-999
D5760	RELINE MAXILLARY PARTIAL DENTURE (laboratory)	C		213.10	0-999
D5761	RELINE MANDIBULAR PARTIAL DENTURE (laboratory )	C		213.10	0-999
D5810	INTERIM COMPLETE DENTURE (maxillary)	N			0-999
D5811	INTERIM COMPLETE DENTURE (mandibular)	N			0-999
D5820	INTERIM PARTIAL DENTURE (maxillary) replace missing Perm & Post Prim teeth	C		358.70	0-999
D5821	INTERIM PARTIAL DENTURE(mandibular) replace missing Perm & Post Prim teeth	C		358.70	0-999
D5850	TISSUE CONDITIONING (maxillary)	C		89.70	0-999

**CMDP**  
**DENTAL BENEFITS MATRIX**  
Effective DOS 10/01/07

BR - By report pays 65% of billed charges					C - Covered Service
BR *- Orthodontics pays 80% of billed charges					N - Non Covered Service
Send x-rays for PA requests and retro reviews only				C -PA - Covered with Prior Authorization Only	
DENTAL CODES	DESCRIPTION	COVERAGE CATEGORY	PA PROCEDURES ONLY	AMOUNT	Age
D5851	TISSUE CONDITIONING (mandibular)	C		89.70	0-999
D5860	OVERDENTURE - COMPLETE	N			0-999
D5861	OVERDENTURE - PARTIAL	N			0-999
D5862	PRECISION ATTACHMENT	N			0-999
D5867	REPLACEMENT OF REPLACEABLE PART (semi-precision or precision attachment)	N			0-999
D5875	MODIFICATION OF REMOVABLE PROSTHESIS (following implant surgery)	N			0-999
D5899	UNSPECIFIED REMOVABLE PROSTHODONTIC PROCEDURE	C - PA		BR	0-999
MAXILLOFACIAL PROSTHETICS (when medically necessary)					
D5911	FACIAL MOULAGE (sectional)	C - PA	Include Narrative	BR	0-999
D5912	FACIAL MOULAGE (complete)	C - PA	Include Narrative	BR	0-999
D5913	NASAL PROSTHESIS	C - PA	Include Narrative	BR	0-999
D5914	AURICULAR PROSTHESIS	C - PA	Include Narrative	BR	0-999
D5915	ORBITAL PROSTHESIS	C - PA	Include Narrative	BR	0-999
D5916	OCULAR PROSTHESIS	C - PA	Include Narrative	BR	0-999
D5919	FACIAL PROSTHESIS	C - PA	Include Narrative	BR	0-999
D5922	NASAL SEPTAL PROSTHESIS	C - PA	Include Narrative	BR	0-999
D5923	OCULAR PROSTHESIS (interim)	C - PA	Include Narrative	BR	0-999
D5924	CRANIAL PROSTHESIS	C - PA	Include Narrative	BR	0-999
05925	FACIAL AUGMENTATION IMPLANT PROSTHESIS	C - PA	Include Narrative	BR	0-999
D5926	NASAL PROSTHESIS (replacement)	C - PA	Include Narrative	BR	0-999

**CMDP**  
**DENTAL BENEFITS MATRIX**  
Effective DOS 10/01/07

BR - By report pays 65% of billed charges				C - Covered Service	
BR *- Orthodontics pays 80% of billed charges				N - Non Covered Service	
Send x-rays for PA requests and retro reviews only				C - PA - Covered with Prior Authorization Only	
DENTAL CODES	DESCRIPTION	COVERAGE CATEGORY	PA PROCEDURES ONLY	AMOUNT	Age
D5927	AURICULAR PROSTHESIS (replacement)	C - PA	Include Narrative	BR	0-999
D5928	ORBITAL PROSTHESIS (replacement)	C - PA	Include Narrative	BR	0-999
D5929	FACIAL PROSTHESIS (replacement)	C - PA	Include Narrative	BR	0-999
D5931	OBTURATOR PROSTHESIS (surgical)	C - PA	Include Narrative	BR	0-999
D5932	OBTURATOR PROSTHESIS (definitive)	C - PA	Include Narrative	BR	0-999
D5933	OBTURATOR PROSTHESIS (modification)	C - PA	Include Narrative	BR	0-999
D5934	MANDIBULAR RESECTION PROSTHESIS (with guide flange)	C - PA	Include Narrative	BR	0-999
D5935	MANDIBULAR RESECTION PROSTHESIS (without guide flange)	C - PA	Include Narrative	BR	0-999
D5936	OBTURATOR PROSTHESIS (interim)	C - PA	Include Narrative	BR	0-999
D5937	TRISMUS APPLIANCE (not for TMD treatment)	C - PA	Include Narrative	BR	0-999
D5951	FEEDING AID	C - PA	Include Narrative	BR	0-2
D5952	SPEECH AID PROSTHESIS (pediatric)	C - PA	Include Narrative	BR	0-16
D5953	SPEECH AID PROSTHESIS (adult)	C - PA	Include Narrative	BR	16-999
D5954	PALATAL AUGMENTATION PROSTHESIS	C - PA	Include Narrative	BR	0-999
D5955	PALATAL LIFT PROSTHESIS (definitive)	C - PA	Include Narrative	BR	0-999
D5958	PALATAL LIFT PROSTHESIS (interim)	C - PA	Include Narrative	BR	0-999
D5959	PALATAL LIFT PROSTHESIS (modification)	C - PA	Include Narrative	BR	0-999
D5960	SPEECH AID PROSTHESIS (modification)	C - PA	Include Narrative	BR	0-999
D5982	SURGICAL STENT	C - PA	Include Narrative	BR	0-999
D5983	RADIATION CARRIER	C - PA	Include Narrative	BR	0-999

**CMDP**  
**DENTAL BENEFITS MATRIX**  
Effective DOS 10/01/07

BR - By report pays 65% of billed charges				C - Covered Service	
BR *- Orthodontics pays 80% of billed charges				N - Non Covered Service	
Send x-rays for PA requests and retro reviews only				C -PA - Covered with Prior Authorization Only	
DENTAL CODES	DESCRIPTION	COVERAGE CATEGORY	PA PROCEDURES ONLY	AMOUNT	Age
D5984	RADIATION SHIELD	C - PA	Include Narrative	BR	0-999
D5985	RADIATION CONE LOCATOR	C - PA	Include Narrative	BR	0-999
D5986	FLUORIDE GEL CARRIER	C - PA	Include Narrative	BR	0-999
D5987	COMMISSURE SPLINT	C - PA	Include Narrative	BR	0-999
D5988	SURGICAL SPLINT	C - PA	Include Narrative	BR	0-999
D5999	UNSPECIFIED MAXIL PROSTHESIS	C - PA	Include Narrative	BR	0-999
IMPLANT SERVICES NOT COVERED (06010-06199)					
PROSTHODONTICS - FIXED (ea retainer/pontic constitutes a unit in a fixed partial denture) (when medically necessary)					
D6205	PONTIC - indirect resin based composite	N			0-20
D6210	PONTIC - cast high noble metal	N			0-999
D6211	PONTIC - cast predominantly based metal	N			0-999
D6212	PONTIC - cast noble metal	N			0-999
D6214	PONTIC - titanium	N			0-20
D6240	PONTIC - porcelain fused to high noble metal	N			0-999
D6241	PONTIC - porcelain fused to predominantly based metal	N			0-999
D6242	PONTIC - porcelain fused to noble metal	N			0-999
D6245	PONTIC - porcelain/ceramic	N			0-999
D6250	PONTIC - resin with high noble metal	N			0-999
D6251	PONTIC - resin with predominantly based metal	N			0-999

**CMDP**  
**DENTAL BENEFITS MATRIX**  
Effective DOS 10/01/07

BR - By report pays 65% of billed charges					C - Covered Service
BR *- Orthodontics pays 80% of billed charges					N - Non Covered Service
Send x-rays for PA requests and retro reviews only				C -PA - Covered with Prior Authorization Only	
DENTAL CODES	DESCRIPTION	COVERAGE CATEGORY	PA PROCEDURES ONLY	AMOUNT	Age
D6252	PONTIC - resin with noble metal	N			0-999
D6253	PROVISIONAL PONTIC	N			0-999
D6545	RETAINER - cast metal for resin bonded fixed prosthesis	N			0-999
D6548	RETAINER - porcelain/ceramic for resin bonded fixed prosthesis	N			0-999
D6600	INLAY - porcelain/ceramic, 2 surfaces	N			0-999
D6601	INLAY - porcelain/ceramic, 3 + surfaces	N			0-999
D6602	INLAY - cast high noble metal, 2 surfaces	N			0-999
D6603	INLAY - cast high noble metal, 3 + surfaces	N			0-999
D6604	INLAY - cast predominantly base metal, 2 surfaces	N			0-999
D6605	INLAY - cast predominantly base metal, 3 + surfaces	N			0-999
D6606	INLAY - cast noble metal, 2 surfaces	N			0-999
D6607	INLAY - cast noble metal, 3 + surfaces	N			0-999
D6624	INLAY - titanium	N			0-20
D6608	ONLAY - porcelain/ceramic, 2 surfaces	N			0-999
D6609	ONLAY - porcelain/ceramic, 3 + surfaces	N			0-999
D6610	ONLAY - cast high noble metal, 2 surfaces	N			0-999
D6611	ONLAY - cast high noble metal, 3 + surfaces	N			0-999
D6612	ONLAY - cast predominantly base metal, 2 surfaces	N			0-999
D6613	ONLAY - cast predominantly base metal, 3 + surfaces	N			0-999
D6614	ONLAY - cast noble metal, 2 surfaces	N			0-999



**CMDP**  
**DENTAL BENEFITS MATRIX**  
Effective DOS 10/01/07

BR - By report pays 65% of billed charges				C - Covered Service	
BR *- Orthodontics pays 80% of billed charges				N - Non Covered Service	
Send x-rays for PA requests and retro reviews only				C -PA - Covered with Prior Authorization Only	
DENTAL CODES	DESCRIPTION	COVERAGE CATEGORY	PA PROCEDURES ONLY	AMOUNT	Age
D6615	ONLAY - cast noble metal, 3 + surfaces	N			0-999
D6634	ONLAY - titanium	N			20-999
D6710	CROWN - indirect resin based composite	N			0-20
D6720	CROWN - resin with high noble metal	N			0-999
D6721	CROWN - resin with predominantly based metal	N			0-999
D6722	CROWN - resin with noble metal	N			0-999
D6740	CROWN - porcelain/ceramic	N			0-999
D6750	CROWN - porcelain fused to high noble metal	N			0-999
D6751	CROWN - porcelain fused to predominantly based metal	N			0-999
D6752	CROWN - porcelain fused to noble metal	N			0-999
D6780	CROWN - 3/4 cast high noble metal	N			0-999
D6781	CROWN - 3/4 cast predominately based metal	N			0-999
D6782	CROWN - 3/4 cast noble metal	N			0-999
D6783	CROWN - 3/4 porcelain/ceramic	N			0-999
D6790	CROWN - full cast high noble metal	N			0-999
D6791	CROWN - full cast predominantly based metal	N			0-999
D6792	CROWN - full cast noble metal	N			0-999
D6793	PROVISIONAL RETAINER CROWN	N			0-999
D6794	CROWN - titanium	N			0-20
D6920	CONNECTOR BAR	N			0-999

**CMDP**  
**DENTAL BENEFITS MATRIX**  
Effective DOS 10/01/07

BR - By report pays 65% of billed charges				C - Covered Service	
BR *- Orthodontics pays 80% of billed charges				N - Non Covered Service	
Send x-rays for PA requests and retro reviews only				C -PA - Covered with Prior Authorization Only	
DENTAL CODES	DESCRIPTION	COVERAGE CATEGORY	PA PROCEDURES ONLY	AMOUNT	Age
D6930	RECEMENT FIXED PARTIAL DENTURE	C		48.50	0-999
D6940	STRESS BREAKER	N			0-999
D6950	PRECISION ATTACHMENT	N			0-999
D6970	CAST POST & CORE (in addition to fixed partial denture retainer)	N			0-999
D6971	CAST POST (as part of fixed partial denture retainer)	N			0-999
D6972	PREFABRICATED POST & CORE (add to fixed partial denture retainer)	N			0-999
D6973	CORE BUILD UP (for retainer, incl any pins)	N			0-999
D6975	COPING - metal	N			0-999
D6976	EACH ADDITIONAL CAST POST same tooth	N			0-999
D6977	EACH ADDITIONAL PREFABRICATED POST same tooth	N			0-999
D6980	FIXED PARTIAL DENTURE REPAIR	N			0-999
D6985	PEDIATRIC PARTIAL DENTURE, fixed	N			0-21
D6999	UNSPECIFIED FIXED PROSTHODONTIC PROCEDURE	C - PA		BR	18-999
<b>ORAL &amp; MAXILLOFACIAL SURGERY</b>					
D7111	EXTRACTION, CORONAL REMNANTS - deciduous tooth	C		60.00	0-999
D7140	EXTRACTION - erupted tooth or exposed root (elevation and/or forceps removal)	C		88.00	0-999
D7210	SURGICAL REMOVAL OF ERUPTED TOOTH requiring elev.	C		135.00	0-999
D7220	REMOVAL OF IMPACTED TOOTH soft tissue	C		165.60	0-999
D7230	REMOVAL OF IMPACTED TOOTH partially bony	C		211.00	0-999
D7240	REMOVAL OF IMPACTED TOOTH completely bony	C		246.90	0-999

**CMDP**  
**DENTAL BENEFITS MATRIX**  
Effective DOS 10/01/07

BR - By report pays 65% of billed charges				C - Covered Service	
BR *- Orthodontics pays 80% of billed charges				N - Non Covered Service	
Send x-rays for PA requests and retro reviews only			C -PA - Covered with Prior Authorization Only		
DENTAL CODES	DESCRIPTION	COVERAGE CATEGORY	PA PROCEDURES ONLY	AMOUNT	Age
D7241	REMOVAL OF IMPACTED TOOTH - comp bony, w/unusual surg complications	C		306.00	0-999
D7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS (cutting proc)	C		135.00	0-999
D7260	OROANTRAL FISTULA CLOSURE	C		316.50	0-999
D7261	PRIMARY CLOSURE OF SINUS PERFORATION	C	Include Narrative	316.50	0-999
D7270	REIMPLANTATION AND/OR STABILIZATION - acc. evulsed or displaced tooth	C	Include Narrative	306.00	0-999
D7272	TOOTH TRANSPLANTATION	N			0-999
D7280	SURG ACCESS OF AN UNERUPTED TOOTH	C	Include x-ray, Narrative	227.90	0-999
D7282	MOBILIZATION OF ERUPTED OR MALPOSITIONED TOOTH - to aid eruption	C	Include x-ray, Narrative	137.20	0-999
D7283	PLACEMENT OF DEVICE - to facilitate eruption of impacted tooth	C	Include x-ray, Narrative	55.90	0-999
D7285	BIOPSY OF ORAL TISSUE hard (bone, tooth)	C		161.40	0-999
D7286	BIOPSY OF ORAL TISSUE soft	C		161.40	0-999
D7287	EXFOLIATIVE CYTOLOGY SAMPLE COLLECTION	N			0-999
D7288	BRUSH BIOPSY - transepithelial sample collection	N			0-20
D7290	SURGICAL REPOSITIONING OF TEETH	N			0-20
D7291	TRANSSEPTAL FIBEROTOMY/SUPRA CRESTAL FIBEROTOMY	N			0-20
D7292	SURGICAL PLACEMENT: temporary anchorage device	C-PA	Include Narrative	BR	0-20
D7293	SURGICAL PLACEMENT: temporary anchorage device requiring surgical flap	C-PA	Include Narrative	BR	0-999
D7294	SURGICAL PLACEMENT: temporary anchorage device without surgical flap	C-PA	Include Narrative	BR	0-999
D7310	ALVEOLOPLASTY IN CONJUNCTION W/EXTRACTIONS - per quadrant	C		160.40	0-999
D7311	ALVEOLOPISTY IN CONJUNCTION W/EXTRACTIONS - 1 to 3 teeth or tooth spaces per quadrant	C		101.30	0-20

**CMDP**  
**DENTAL BENEFITS MATRIX**  
Effective DOS 10/01/07

BR - By report pays 65% of billed charges				C - Covered Service	
BR *- Orthodontics pays 80% of billed charges				N - Non Covered Service	
Send x-rays for PA requests and retro reviews only			C -PA - Covered with Prior Authorization Only		
DENTAL CODES	DESCRIPTION	COVERAGE CATEGORY	PA PROCEDURES ONLY	AMOUNT	Age
D7320	ALVEOLOPLASTY NOT IN CONJUNCTION W/EXTRACTIONS - per quadrant	C		211.00	0-999
D7321	ALVEOLOPLASTY NOT IN CONJUNCTION W/EXTRACTIONS - 1 to 3 teeth or tooth spaces per quadrant	C		140.30	0-20
D7340	VESTIBULOPLASTY - ridge extension (2nd epithelialization)	N			0-999
D7350	VESTIBULOPLASTY - ridge extension (incl/soft tissue grafts)	N			0-999
D7410	EXCISION OF BENIGN LESION up to 1.25 cm	C		111.80	0-999
D7411	EXCISION OF BENIGN LESION greater than 1.25 cm	C		247.90	0-999
D7412	EXCISION OF BENIGN LESION, complicated	C		290.10	0-999
D7413	EXCISION OF MALIGNANT LESION up to 1.25 cm	C		221.60	0-999
D7414	EXCISION OF MALIGNANT LESION greater than 1.25 cm	C		327.10	0-999
D7415	EXCISION OF MALIGNANT LESION, complicated	C		342.90	0-999
D7440	EXCISION OF MALIGNANT TUMOR up to 1.25	C		216.30	0-999
D7441	EXCISION OF MALIGNANT TUMOR greater than 1.25cm	C		321.80	0-999
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST/TUMOR - up to 1.25cm	C		160.40	0-999
D7451	REMOVAL OF BENIGN ODONTOGENIC CYST/TUMOR - greater than 1.25cm	C		205.70	0-999
D7460	REMOVAL OF BENIGN NONODONTOGENIC CYST/TUMOR - up to 1.25cm	C		117.10	0-999
D7461	REMOVAL OF BENIGN NONODONTOGENIC CYST/TUMOR - greater than 1.25cm	C		155.00	0-999
D7465	DESTRUCTION OF LESION by physical or chemical method	C		75.00	0-999
D7471	REMOVAL OF LATERAL EXOSTOSIS (maxilla/mandible)	C - PA	Include Narrative	250.00	0-999
D7472	REMOVAL OF TORUS PALATINUS	C - PA	Include Narrative	350.00	0-999
D7473	REMOVAL OF TORUS MANDIBULARIS	C - PA	Include Narrative	550.00	0-999

**CMDP**  
**DENTAL BENEFITS MATRIX**  
Effective DOS 10/01/07

BR - By report pays 65% of billed charges				C - Covered Service	
BR *- Orthodontics pays 80% of billed charges				N - Non Covered Service	
Send x-rays for PA requests and retro reviews only				C - PA - Covered with Prior Authorization Only	
DENTAL CODES	DESCRIPTION	COVERAGE CATEGORY	PA PROCEDURES ONLY	AMOUNT	Age
D7485	SURGICAL REDUCTION OF OSSEOUS TUBEROSITY	C - PA	Include Narrative	285.00	0-999
D7490	RADICAL RESECTION OF MAXILLA OR MANDIBLE with bone graft	C - PA	Include Narrative	3450.00	0-999
D7510	INCISION AND DRAINAGE OF ABSCESS intraoral soft tissue	C		75.00	0-999
D7511	INCISION AND DRAINAGE OF ABSCESS-intraoral soft tissue - complicated	C		250.00	0-999
D7520	INCISION AND DRAINAGE OF ABSCESS extraoral soft tissue	C		135.00	0-999
D7521	INCISION AND DRAINAGE OF ABSCESS -extraoral soft tissue-complicated	C		275.00	0-999
D7530	REMOVAL OF FOREIGN BODY, SKIN OR SUBCUTANEOUS ALVEOLAR TISSUE	C		93.00	0-999
D7540	REMOVAL OF REACTION-PRODUCING FOREIGN BODIES, musculoskeletal system	C		115.00	0-999
D7550	PARTIAL OSTECTOMY/SEQUESTRECTOMY FOR REMOVAL OF NON-VITAL BONE	C		190.00	0-999
D7560	MAXILLARY SINUSOTOMY - REMOVAL OF TOOTH FRAGMENT OR FOREIGN BODY	C - PA		365.00	0-999
TREATMENT OF FRACTURES (when medically necessary)					
D7610	MAXILLA - open reduction	C - PA	Include Narrative	1750.00	0-999
D7620	MAXILLA - closed reduction	C - PA	Include Narrative	1250.00	0-999
D7630	MANDIBLE - open reduction	C - PA	Include Narrative	2132.00	0-999
D7640	MANDIBLE - closed reduction	C - PA	Include Narrative	1100.00	0-999
D7650	MALAR AND/OR ZYGOMATIC ARCH open reduction	C - PA	Include Narrative	1250.00	0-999
D7660	MALAR AND/OR ZYGOMATIC ARCH closed reduction	C - PA	Include Narrative	850.00	0-999
D7670	ALVEOLUS CLOSED REDUCTION, may include stabilization of teeth	C - PA	Include Narrative	343.00	0-999
D7671	ALVEOLUS OPEN REDUCTION, may include stabilization of teeth	C - PA	Include Narrative	1725.00	0-999
D7680	FACIAL BONES complicated reduction w/fixation	C - PA	Include Narrative	2850.00	0-999

**CMDP**  
**DENTAL BENEFITS MATRIX**  
Effective DOS 10/01/07

BR - By report pays 65% of billed charges				C - Covered Service	
BR *- Orthodontics pays 80% of billed charges				N - Non Covered Service	
Send x-rays for PA requests and retro reviews only				C - PA - Covered with Prior Authorization Only	
DENTAL CODES	DESCRIPTION	COVERAGE CATEGORY	PA PROCEDURES ONLY	AMOUNT	Age
D7710	MAXILLA - open reduction	C - PA	Include Narrative	1950.00	0-999
D7720	MAXILLA - closed reduction	C - PA	Include Narrative	1195.00	0-999
D7730	MANDIBLE - open reduction	C - PA	Include Narrative	2050.00	0-999
D7740	MANDIBLE - closed reduction	C - PA	Include Narrative	1290.00	0-999
D7750	MALAR AND/OR ZYGOMATIC ARCH open reduction	C - PA	Include Narrative	1875.00	0-999
D7760	MALAR AND/OR ZYGOMATIC ARCH closed reduction	C - PA	Include Narrative	1295.00	0-999
D7770	ALVEOLUS - open reduction stabilization of teeth	C - PA	Include Narrative	1250.00	0-999
D7771	ALVEOLUS - closed reduction stabilization of teeth	C - PA	Include Narrative	725.00	0-999
D7780	FACIAL BONES complicated reduction with fixation	C - PA	Include Narrative	3590.00	0-999
<b>REDUCTION OF DISLOCATION &amp; MANAGEMENT OF OTHER TEMPOROMANDIBULAR JOINT DYSFUNCTIONS (when medically necessary)</b>					
D7810	OPEN REDUCTION OF DISLOCATION	C - PA	Include Narrative	1790.00	0-999
D7820	CLOSED REDUCTION OF DISLOCATION	C - PA	Include Narrative	155.00	0-999
D7830	MANIPULATION WITH ANESTHESIA	C - PA	Include Narrative	235.00	0-999
D7840	CONDYLECTOMY	C - PA	Include Narrative	2275.00	0-999
D7850	SURGICAL DISCECTOMY with/without implant	C - PA	Include Narrative	2075.00	0-999
D7852	DISC REPAIR	C - PA	Include Narrative	BR	0-999
D7854	SYNOVECTOMY	C - PA	Include Narrative	2590.00	0-999
D7856	MYOTOMY	C - PA	Include Narrative	1358.00	0-999
D7858	JOINT RECONSTRUCTION	C - PA	Include Narrative	2717.00	0-999
D7860	ARTHROTOMY	C - PA	Include Narrative	535.00	0-999

**CMDP**  
**DENTAL BENEFITS MATRIX**  
Effective DOS 10/01/07

BR - By report pays 65% of billed charges				C - Covered Service	
BR *- Orthodontics pays 80% of billed charges				N - Non Covered Service	
Send x-rays for PA requests and retro reviews only			C -PA - Covered with Prior Authorization Only		
DENTAL CODES	DESCRIPTION	COVERAGE CATEGORY	PA PROCEDURES ONLY	AMOUNT	Age
D7865	ARTHROPLASTY	C - PA	Include Narrative	2717.00	0-999
D7870	ARTHROCENTESIS	C - PA	Include Narrative	165.00	0-999
D7871	NON-ARTHROSCOPIC LYSIS AND LAVAGE	C - PA	Include Narrative	300.00	0-999
D7872	ARTHROSCOPY diagnosis, with/without biopsy	C - PA	Include Narrative	465.00	0-999
D7873	ARTHROSCOPY surgical: lavage and lysis of adhesions	C - PA	Include Narrative	1215.00	0-999
D7874	ARTHROSCOPY - surgical:disc repositioning and stabilization	C - PA	Include Narrative	1215.00	0-999
D7875	ARTHROSCOPY surgical: synovectomy	C - PA	Include Narrative	1642.00	0-999
D7876	ARTHROSCOPY surgical: discectomy	C - PA	Include Narrative	1642.00	0-999
D7877	ARTHROSCOPY surgical: debridement	C - PA	Include Narrative	2717.00	0-999
D7880	OCCLUSAL ORTHOTIC DEVICE	C - PA	Include Narrative	333.00	0-999
D7899	UNSPECIFIED TMD THERAPY	C - PA	Include Narrative	249.00	0-999
REPAIR OF TRAUMATIC WOUNDS					
D7910	SUTURE OF RECENT SMALL WOUND up to 5 cm	C		70.00	0-999
D7911	COMPLICATED SUTURE up to 5 CM	C		118.00	0-999
D7912	COMPLICATED SUTURE greater than 5 CM	C		275.00	0-999
D7920	SKIN GRAFTS	C - PA	Include Narrative	BR	0-999
D7940	OSTEOPLASTY for orthognathic deformities	C - PA	Include x-ray, Narrative	1250.00	0-999
D7941	OSTEOTOMY mandibular rami	C - PA	Include x-ray, Narrative	3450.00	0-999
D7943	OSTEOTOMY mandibular rami w/bone graft	C - PA	Include x-ray, Narrative	3450.00	0-999
D7944	OSTEOTOMY segmented or subapical per quad	C - PA	Include x-ray, Narrative	2895.00	0-999

**CMDP**  
**DENTAL BENEFITS MATRIX**  
Effective DOS 10/01/07

BR - By report pays 65% of billed charges				C - Covered Service	
BR *- Orthodontics pays 80% of billed charges				N - Non Covered Service	
Send x-rays for PA requests and retro reviews only				C-PA - Covered with Prior Authorization Only	
DENTAL CODES	DESCRIPTION	COVERAGE CATEGORY	PA PROCEDURES ONLY	AMOUNT	Age
D7945	OSTEOTOMY - body of mandible	C - PA	Include x-ray, Narrative	3125.00	0-999
D7946	LEFORT I - maxilla -total	C - PA	Include x-ray, Narrative	3490.00	0-999
D7947	LEFORT I - maxilla-segmented	C - PA	Include x-ray, Narrative	3195.00	0-999
D7948	LEFORT II/III - without bone graft	C - PA	Include x-ray, Narrative	3999.00	0-999
D7949	LEFORT II/III - with bone graft	C - PA	Include x-ray, Narrative	4150.00	0-999
D7950	OSSEOUS, OSTEOPERIOSTEAL, OR CARTILAGE GRAFT/MANDIBLE OR MAXILLA-AUTOGENOUS OR NONAUTOGENOUS FACIAL BONE	C - PA	Include x-ray, Narrative	895.00	0-999
D7951	SINUS AUGMENTATION WITH BONE OR BONE SUBSTITUTES	C-PA	Include x-ray, Narrative	BR	0-999
D7953	BONE REPLACEMENT GRAFT FOR RIDGE PRESERVATION - per site	C-PA	Include x-ray, Narrative	BR	0-20
D7955	REPAIR OF MAXILLOFACIAL SOFT/HARD TISSUE DEFECT	C - PA	Include Narrative	905.00	0-999
D7960	FRENULECTOMY - separate procedure	C - PA	Include Narrative	146.00	0-999
D7963	FRENULOPLASTY	C		146.00	0-20
D7970	EXCISION OF HYPERPLASTIC TISSUE per arch	C		152.00	0-999
D7971	EXCISION OF PERICORONAL GINGIVA	C		74.00	0-999
D7972	SURGICAL REDUCTION OF FIBROUS TUBEROSITY	C		125.00	0-999
D7980	SIALOLITHOTOMY	C		195.00	0-999
D7981	EXCISION OF SALIVARY GLAND	C - PA	Include Narrative	755.00	0-999
D7982	SIALODOCHOPLASTY	C - PA	Include Narrative	550.00	0-999
D7983	CLOSURE OF SALIVARY FISTULA	C - PA	Include Narrative	205.00	0-999
D7990	EMERGENCY TRACHEOTOMY	C	Include Narrative	365.00	0-999
D7991	CORONOIDECTOMY	C - PA	Include Narrative	1275.00	0-999



**CMDP**  
**DENTAL BENEFITS MATRIX**  
Effective DOS 10/01/07

BR - By report pays 65% of billed charges				C - Covered Service	
BR *- Orthodontics pays 80% of billed charges				N - Non Covered Service	
Send x-rays for PA requests and retro reviews only				C-PA - Covered with Prior Authorization Only	
DENTAL CODES	DESCRIPTION	COVERAGE CATEGORY	PA PROCEDURES ONLY	AMOUNT	Age
D7995	SYNTHETIC GRAFT mandible or facial bones	C - PA	Include Narrative	BR	0-999
D7996	IMPLANT mandible for augmentation process	C - PA	Include x-ray, Narrative	BR	0-999
D7997	APPLIANCE REMOVAL - includes removal of archbar (not by same dentist)	C-PA		BR	0-999
D7998	INTRAORAL PLMNT OF FIXATION DEVICE NOT IN CONJUT W/A FRACTURE	C-PA	Include Narrative	BR	0-999
D7999	UNSPECIFIED ORAL SURGERY	C - PA	Include Narrative	BR	0-999
<b>ORTHODONTICS (when medically necessary)</b>					
D8010	LIMITED ORTHODONTIC TREATMENT OF THE PRIMARY DENTITION	C - PA	Include x-ray, Narrative	295.40	0-20
D8020	LIMITED ORTHODONTIC TREATMENT OF TRANSITIONAL DENTITION	C - PA	Include x-ray, Narrative	295.40	0-20
D8030	LIMITED ORTHODONTIC TREATMENT OF ADOLESCENT DENTITION	C - PA	Include x-ray, Narrative	295.40	0-20
D8040	LIMITED ORTHODONTIC TREATMENT OF ADULT DENTITION	C - PA	Include x-ray, Narrative	295.40	0-20
D8050	INTERCEPTIVE ORTHODONTIC TREATMENT OF THE PRIMARY DENTITION	C - PA	Include x-ray, Narrative	1371.50	0-20
D8060	INTERCEPTIVE ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION	C - PA	include orthodontic records, x-ray, & narrative	1371.50	0-20
D8070	COMPREHENSIVE ORTHO TREATMENT OF THE TRANSITIONAL DENTITION	C - PA	include orthodontic records, x-ray, & narrative	2743.00	0-20
D8080	COMPREHENSIVE ORTHO TREATMENT OF THE ADOLESCENT DENTITION	C - PA	include orthodontic records, x-ray, & narrative	3084.80	0-20
D8090	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADULT DENTITION	C - PA	include orthodontic records, x-ray, & Narrative	3192.40	0-20
D8210	REMOVABLE APPLIANCE THERAPY	C - PA	Include x-ray, Narrative	321.80	0-20
D8220	FIXED APPLIANCE THERAPY	C - PA	Include x-ray, Narrative	353.40	0-20
D8660	PRE-ORTHODONTIC TREATMENT VISIT	C		47.50	0-20
D8670	PERIODIC ORTHODONTIC TREATMENT VISIT - as part of contract	C		139.30	0-20
D8680	ORTHODONTIC RETENTION -removal of appliances, placement of retainer(s)	C - PA		211.00	0-20

**CMDP**  
**DENTAL BENEFITS MATRIX**  
Effective DOS 10/01/07

BR - By report pays 65% of billed charges					C - Covered Service
BR *- Orthodontics pays 80% of billed charges					N - Non Covered Service
Send x-rays for PA requests and retro reviews only				C -PA - Covered with Prior Authorization Only	
DENTAL CODES	DESCRIPTION	COVERAGE CATEGORY	PA PROCEDURES ONLY	AMOUNT	Age
D8690	ORTHODONTIC TREATMENT alternative billing to a contract fee	C - PA		68.60	0-20
D8691	REPAIR OF ORTHODONTIC APPLIANCE	C - PA		BR *	0-20
D8692	REPLACEMENT OF LOST OR BROKEN RETAINER	C - PA		137.20	0-20
D8693	REBONDING OR RECEMENTING; AND/OR REPAIR, AS REQUIRED OF FIXED RETAINER	C		48.50	0-20
D8999	UNSPECIFIED ORTHODONTIC PROCEDURE	C - PA	Include Narrative	BR *	0-20
ADJUNCTIVE GENERAL SERVICES					
D9110	PALLIATIVE EMERGENCY TREATMENT OF DENTAL PAIN - minor procedure	C		60.10	0-999
D9120	FIXED PARTIAL DENTURE SECTIONING	C		54.90	0-999
ANESTHESIA					
D9210	LOCAL ANESTHESIA not in conjunction w/operative or surgical procedures	C		10.60	0-999
D9211	REGIONAL BLOCK ANESTHESIA	N			0-999
D9212	TRIGEMINAL DIVISION BLOCK ANESTHESIA	N			0-999
D9215	LOCAL ANESTHESIA	N			0-999
D9220	DEEP SEDATION/GENERAL ANESTHESIA first 30 minutes	C - PA	Include Narrative	150.00	0-999
D9221	DEEP SEDATION/GENERAL ANESTHESIA each additional 15 minutes	C	Include Narrative	68.00	0-999
D9230	ANALGESIA, ANXIOLYSIS, INHALATION OF NITROUS OXIDE	C		26.40	0-999
D9241	INTRAVENOUS CONSCIOUS SEDATION/ANALGESIA first 30 minutes	C - PA		140.30	0-999
D9242	INTRAVENOUS CONSCIOUS SED./ANALGESIA each add. 15 min	C - PA		40.10	0-999
D9248	NON-INTRAVENOUS CONSCIOUS SEDATION	C		63.30	0-999
PROFESSIONAL CONSULTATION					

**CMDP**  
**DENTAL BENEFITS MATRIX**  
Effective DOS 10/01/07

BR - By report pays 65% of billed charges				C - Covered Service	
BR *- Orthodontics pays 80% of billed charges				N - Non Covered Service	
Send x-rays for PA requests and retro reviews only			C -PA - Covered with Prior Authorization Only		
DENTAL CODES	DESCRIPTION	COVERAGE CATEGORY	PA PROCEDURES ONLY	AMOUNT	Age
D9310	CONSULTATION (diag. service provider by dentist or phys. Other than requesting dentist or phys.)	C	Include Narrative	41.10	0-999
PROFESSIONAL VISITS					
D9410	HOUSE/EXTENDED CARE FACILITY CALL	C	Include Narrative	47.50	0-999
D9420	HOSPITAL CALL	C		84.40	0-999
D9430	OFFICE VISIT FOR OBSERVATION no other services performed	C		29.50	0-999
D9440	OFFICE VISIT after regularly scheduled hours	C		66.50	0-999
D9450	CASE PRESENTATION, detailed and extensive treatment planning	N			0-999
D9610	THERAPEUTIC DRUG INJECTION	C		20.00	0-999
D9612	THERAPEUTIC PARENTERAL DRUGS, two or more admin., different medications	C		31.70	0-999
D9630	OTHER DRUG/MEDICAMENTS	N			0-999
D9910	APPLICATION OF DESENSITIZING MEDICATION	N			0-999
D9911	APPLICATION OF DESENSITIZING RESIN for cervical /root service , per tooth	N			0-999
D9920	BEHAVIOR MANAGEMENT	C		36.90	0-20
D9930	TREATMENT OF COMPLICATION post surgical	C		29.50	0-999
D9940	OCCLUSAL GUARD	C - PA	Include Narrative	189.90	0-20
D9941	FABRICATION OF ATHLETIC MOUTHGUARD	N			0-20
D9942	REPAIR AND /OR RELINE OF OCCLUSAL GRUARD	N			0-20
D9950	OCCLUSION ANALYSIS - mounted case	N			0-20
D9951	OCCLUSAL ADJUSTMENT -limited	C		51.70	0-20
D9952	OCCLUSAL ADJUSTMENT - complete	N			00-20

**CMDP**  
**DENTAL BENEFITS MATRIX**  
Effective DOS 10/01/07

BR - By report pays 65% of billed charges				C - Covered Service	
BR *- Orthodontics pays 80% of billed charges				N - Non Covered Service	
Send x-rays for PA requests and retro reviews only			C -PA - Covered with Prior Authorization Only		
DENTAL CODES	DESCRIPTION	COVERAGE CATEGORY	PA PROCEDURES ONLY	AMOUNT	Age
D9970	ENAMEL MICROABRASION	N			0-999
D9971	ODONTOPLASTY 1-2 TEETH -includes removal of enamel projections	N			0-999
D9972	EXTERNAL BLEACHING - PER ARCH	N			0-999
D9973	EXTERNAL BLEACHING - PER TOOTH	N			0-999
D9974	INTERNAL BLEACHING - PER TOOTH	N			0-999
D9999	UNSPECIFIED ADJUNCTIVE PROCEDURE	C - PA	Include Narrative	BR	0-999